

Exhibit 12



22 B109305

17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name: _____

Date: 6/23/10

Diagnosis: 1. CTL Strain

Diagnosis: 2. _____

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate & Treat: X

Area: CTL Spinal

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

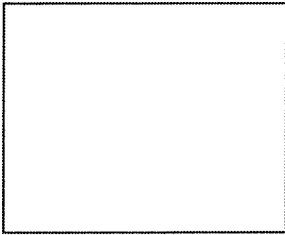
Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: [Signature]

Date: 6/23/10



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Occupational Therapy Prescription

Patients Name: [Redacted] Date 10/27/10

Diagnosis: 1. Post MVA H.A

Diagnosis: 2. _____

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate & Treat: X Area: Head

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: [Signature] Date: 10/27/10



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Physical Therapy Prescription

Patients Name: [Redacted]

Date 12/22/10

Diagnosis: 1. Acute / Chronic Ankle Sprain

Diagnosis: 2. _____

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate & Treat: 2

Area: C/L

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Andrew Ruden, M.D.

Physicians Signature: [Signature] Date: 12/22/10



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Physical Therapy Prescription

Patients Name: _____

Date 9/22/10

Diagnosis: 1. CTL Strain No Rad

Diagnosis: 2. _____

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate & Treat: X

Area: CTL Spine

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: [Signature]

Date: 9/22/10



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Occupational Therapy Prescription

Patients Name:

Date

9/22/10

Diagnosis: 1.

Post Concussive H.A.

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat:

Area:

Head.

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency:

3 times/week

Duration:

4 weeks

Onset Date:

Precautions:

Physicians Name:

Martin Quiroga, DO

Physicians Signature:

Date:

9/22/10